

## Intervention report (excerpts)

Intervention at Centre intégré de santé et de services sociaux des Laurentides  
and with the Curateur public du Québec

Québec City, September 6, 2017

### The intervention

The Québec Ombudsman received a report about shortcomings in the quality of the care and services provided to the residents at Résidence le Geai bleu inc. (the Residence). The report specified that the residents were supervised by Centre intégré de santé et de services sociaux des Laurentides and that several of them were also under the protective supervision of the Curateur public du Québec. The report concerned the following elements:

- ▶ Unsanitary premises, mould and unpleasant odours;
- ▶ A heating system that does not work properly and that causes excessive humidity in the house when the system breaks down;
- ▶ No single rooms (rooms must be shared);
- ▶ Food of insufficient quality and quantity;
- ▶ One of two bathrooms cannot be used because of its disrepair;
- ▶ Deficient supervision of the users and insufficient staff to meet the needs of the most vulnerable residents;
- ▶ At certain times of the day, no employees on duty.

### Conclusion

The Québec Ombudsman intervened further to a report concerning service quality at a residence that houses people supervised by CISSS des Laurentides.

The intervention made it possible to determine the accuracy of different claims but without being able to decide as to the Residence's ability to respond to the needs of its client population based on objective and measurable standards.

The investigation by the Québec Ombudsman did not reveal situations in which residents' integrity was violated or situations of physical assault, but it showed very clearly that the living environment had limitations regarding supervision.

While the Residence meets a genuine residential need in this region, there were major operational flaws in terms of the human and financial resources needed to establish a slate of services based on the users' needs.

The Québec Ombudsman also concluded that the CISSS operated in a vacuum both clinically and administratively. One of the effects of this situation was that throughout the investigation, the Québec Ombudsman obtained fragmented, incomplete, narrow and even contradictory answers.

Yet the CISSS must ensure that there are quality standards and the required services in the various residential facilities to which it refers people, but it is apparent that for such partnerships there must first be formal contractual ties between the parties concerned so as to prevent any ambiguity concerning service provision. The Québec Ombudsman feels all the more that the lack of formal contractual ties with the Residence must not absolve the CISSS from its responsibilities given that it is the main intermediary for referral to the Residence.

Despite the limitations observed and collated by the CISSS in its administrative investigation into service provision by the Residence, it is unfair to lay all the blame on the administrators of the Residence given that they receive substantially lower funding than that of a “similar” environment for services that are usually regulated. Not only was the CISSS aware of these issues, but it had endorsed the Residence for several years by continuing to refer people to it.

The Québec Ombudsman cannot ignore the residents’ attachment to this living environment and the need to do everything to maintain the Residence’s services so that the people who live there do not have to move. However, it is crucial that keeping these residents in their current living environment must involve the establishment of services subject to objective and measurable standards. Consequently, it is essential that the status of the Residence be clarified, that it have the financial resources it needs to fulfil its obligations regarding the residents, and that the CISSS clarify its practices and the applicable standards on the administrative and clinical levels alike.

### Recommendations

Given the preceding, the Québec Ombudsman recommended that Centre intégré de santé et de services sociaux des Laurentides:

- R-1 **Clarify** the clinical process and the access mechanism through which CISSS service programs must navigate before referring a person to Résidence le Geai bleu inc;
- R-2 **Standardize** the process for supervising all the resources to which the CISSS refers people so that there is an integrated clinical and administrative structure;
- R-3 **Ensure that the CISSS’s clinical staff understand and apply** the quality standards to which the different residential facilities are subject before referring people to them;
- R-4 **Clarify and officialize** the status and nature of the contractual tie with Résidence le Geai bleu inc.;
- R-5 **Keep** the residents at Résidence le Geai bleu inc. while its status is being officialized. Where applicable, obtain the consent of the person or the person’s legal representative and inform the Québec Ombudsman of the reasons for a relocation beforehand.

Given the preceding, the Québec Ombudsman recommended that the Ministère de la Santé et des Services sociaux du Québec:

- R-6 **Support** CISSS des Laurentides in its process to officialize the Residence’s status, maintain the residents’ stability and ensure that the services offered comply with objective and measurable quality standards.

Given the preceding, the Québec Ombudsman recommended that the Curateur public du Québec:

R-7 **Ensure** that formal confirmation of the legal status of a residential facility and the nature of the contractual tie with the health and social services network is obtained before entrusting the facility with a person under protective supervision.

Not later than October 6, 2017, **inform** the Québec Ombudsman of the measures established to implement these recommendations.

#### **Expected follow-up**

As provided for in the *Act respecting the Health and Social Services Ombudsman* (CQLR, c. P-31.1), within 30 days of receiving this report, the institution must inform the Québec Ombudsman that it agrees to implement the recommendations made to it, or if the institution has decided not to act on them, of the reasons for it.